

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041517</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Heritage Manor-Gillespie</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>R.R. #2 P.O. BOX 3B</u> <u>Gillespie</u> <u>61701</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>MACOUPIN</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(217) 839-2171</u> Fax # () _____		(Type or Print Name) <u>CRAIG L. ATER</u>	
IDPA ID Number: <u>370909086017</u>		(Title) <u>Senior Vice President -- Finance</u>	
Date of Initial License for Current Owners: <u>03/01/96</u>		Paid Preparer (Signed) _____ (Date) _____	
Type of Ownership:		(Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> GOVERNMENTAL		(Firm Name & Address) _____	
<input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Individual <input type="checkbox"/> State		(Telephone) <u>(309) 823-7135</u> Fax # () _____	
<input type="checkbox"/> Trust <input type="checkbox"/> Partnership <input type="checkbox"/> County		MAIL TO: OFFICE OF HEALTH FINANCE	
IRS Exemption Code _____ <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Other _____		ILLINOIS DEPARTMENT OF PUBLIC AID	
Limited Liability Co.		201 S. Grand Avenue East	
Trust		Springfield, IL 62763-0001	
Other _____		Phone # (217) 782-1630	
In the event there are further questions about this report, please contact:			
Name: <u>CRAIG L. ATER</u>			
Telephone Number: () _____			

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Heritage Manor-Gillespie# 0041517 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>118</u>	Skilled (SNF)	<u>118</u>	<u>43,070</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4		Intermediate/DD			4
5	<u>0</u>	Sheltered Care (SC)	<u>0</u>	<u>0</u>	5
6		ICF/DD 16 or Less			6
7	<u>118</u>	TOTALS	<u>118</u>	<u>43,070</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>19,071</u>	<u>14,531</u>	<u>2,803</u>	<u>36,405</u>	8
9	SNF/PED			<u>0</u>		9
10	ICF					10
11	ICF/DD					11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,071</u>	<u>14,531</u>	<u>2,803</u>	<u>36,405</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 84.53%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 03/01/96

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date 03/01/96 NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided 2,803

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Heritage Manor-Gillespie

0041517

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	143,528	11,454		154,982		154,982	4,043	159,025			1
2	Food Purchase		142,682		142,682		142,682	(857)	141,825			2
3	Housekeeping	81,553	13,176		94,729		94,729		94,729			3
4	Laundry	40,062	13,747		53,809		53,809		53,809			4
5	Heat and Other Utilities			94,038	94,038		94,038	1,258	95,296			5
6	Maintenance	47,313	25,232	28,811	101,356		101,356	10,880	112,236			6
7	Other (specify):*											7
8	TOTAL General Services	312,456	206,291	122,849	641,596		641,596	15,324	656,920			8
	B. Health Care and Programs											
9	Medical Director			1,250	1,250		1,250		1,250			9
10	Nursing and Medical Records	1,233,532	58,170	12,315	1,304,017		1,304,017		1,304,017			10
10a	Therapy		194,464	79,380	273,844	(310,659)	(36,815)	103,987	67,172			10a
11	Activities	47,825	2,453	1,995	52,273		52,273		52,273			11
12	Social Services	28,081	608	3,198	31,887		31,887		31,887			12
13	Nurse Aide Training	3,628			3,628		3,628	2,248	5,876			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,313,066	255,695	98,138	1,666,899	(310,659)	1,356,240	106,235	1,462,475			16
	C. General Administration											
17	Administrative	65,915			65,915		65,915	104,490	170,405			17
18	Directors Fees							5,546	5,546			18
19	Professional Services			251,037	251,037		251,037	(240,596)	10,441			19
20	Dues, Fees, Subscriptions & Promotions			82,402	82,402	(64,605)	17,797	(2,895)	14,902			20
21	Clerical & General Office Expenses	90,568	7,644	17,983	116,195		116,195	219,782	335,977			21
22	Employee Benefits & Payroll Taxes			298,119	298,119		298,119	28,739	326,858			22
23	Inservice Training & Education			703	703		703	902	1,605			23
24	Travel and Seminar			5,794	5,794		5,794	(3,795)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			43,666	43,666		43,666	2,117	45,783			26
27	Other (specify):*			24,145	24,145		24,145	(24,064)	81			27
28	TOTAL General Administration	156,483	7,644	723,849	887,976	(64,605)	823,371	90,226	913,597			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,782,005	469,630	944,836	3,196,471	(375,264)	2,821,207	211,785	3,032,992			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Heritage Manor-Gillespie

#0041517

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			154,641	154,641		154,641	10,325	164,966			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			178,777	178,777		178,777	215	178,992			32
33	Real Estate Taxes			26,528	26,528		26,528		26,528			33
34	Rent-Facility & Grounds							7,930	7,930			34
35	Rent-Equipment & Vehicles			5,745	5,745		5,745	14,566	20,311			35
36	Other (specify):*											36
37	TOTAL Ownership			365,691	365,691		365,691	33,036	398,727			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					310,659	310,659		310,659			39
40	Barber and Beauty Shops		373	10,455	10,828		10,828		10,828			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					64,605	64,605		64,605			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		373	10,455	10,828	375,264	386,092		386,092			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,782,005	470,003	1,320,982	3,572,990		3,572,990	244,821	3,817,811			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heritage Manor-Gillespie# 0041517

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1 Amount	2 Refer- ence	3 OHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms	(1,119)	35		5
6 Rented Facility Space		34		6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation		30		9
10 Interest and Other Investment Income	(44)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(857)	2		13
14 Non-Care Related Interest		32		14
15 Non-Care Related Owner's Transactions		33		15
16 Personal Expenses (Including Transportation)		24		16
17 Non-Care Related Fees	(916)	20		17
18 Fines and Penalties				18
19 Entertainment	(10,818)	24		19
20 Contributions	(64)	27		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers	(745)	19		22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(24,000)	27		24
25 Fund Raising, Advertising and Promotional	(6,279)	20		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule Real estate taxes		33		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (44,842)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1 Amount	2 Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	289,663		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 289,663		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 244,821		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1 Yes	2 No	3 Amount	4 Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Heritage Manor-Gillespie

ID# 0041517

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$	0	0
2		0	0
3		0	0
4		0	0
5		(1,119)	35
6		0	34
7		0	
8		0	
9		0	30
10			32
11		0	
12		0	
13		(857)	2
14		0	32
15		0	33
16		0	24
17		(916)	20
18		0	
19			24
20		(64)	27
21		0	
22		(745)	19
23		0	
24		(24,000)	27
25		(6,279)	20
26		0	0
27		0	0
28		0	0
29		0	0
30		0	0
31		0	0
32			
33		0	33
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49	Total	(33,980)	

Summary A

12/31/2002

(to Sch V, col.7)

[illegible]

Summary B

12/31/2002

12/31/2002

[illegible]

Facility Name & ID Number Heritage Manor-Gillespie# 0041517

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V	10a Adjustment for Related Organization	70,420	GreenTree Therapy	100.00%	65,354	(5,066)	2
3	V							3
4	V	19 Adjustment for Related Organization	250,292	Heritage Enterprises, Inc.	100.00%		(250,292)	4
5	V							5
6	V	10a Adjustment for Related Organization	197,526	GreenTree Pharmacy	100.00%	306,579	109,053	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 518,238			\$ 371,933	\$ * (146,305)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Gillespie# 0041517Report Period Beginning: 1/01/2002Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 4,043	\$ 4,043	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				0		17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,258	1,258	19
20	V	6 Maintenance				10,880	10,880	20
21	V	7 Other				0		21
22	V	9 Medical Director				0		22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				0		24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				2,248	2,248	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				104,490	104,490	29
30	V	18 Directors Fees				5,546	5,546	30
31	V	19 Professional Services				10,441	10,441	31
32	V	20 Fees, Subscription, Promotions				4,300	4,300	32
33	V	21 Clerical & General Office Expenses				219,782	219,782	33
34	V	22 Employee Benefits & Payroll Taxes				28,739	28,739	34
35	V	23 Inservice Training & Education				902	902	35
36	V	24 Travel and Seminar				7,023	7,023	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				2,117	2,117	38
39	Total		\$			\$ 401,769	\$ *	401,769 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Gillespie# 0041517Report Period Beginning: 1/01/2002Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	27 Other	\$	Heritage Enterprises, Inc.	100.00%	\$ 0	\$
16	V	30 Depreciation				10,325	10,325
17	V	31 Amortization of Pre-Op & Org				0	
18	V	32 Interest				259	259
19	V	33 Real Estate Taxes				0	
20	V	34 Rent-Facility & Grounds				7,930	7,930
21	V	35 Rent-Equipment & Vehicles				15,685	15,685
22	V	36 Other				0	
23	V	38 Medically Nec Transportation				0	
24	V	39 Ancillary Service Centers				0	
25	V	40 Barber and Beauty Shops				0	
26	V	41 Coffee and Gift Shops				0	
27	V	42 Other				0	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 34,199	\$ * 34,199

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Heritage Manor-Gillespie # 0041517 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Board	Management	26.00	397,396	5	100.00	Director/Salary	\$ 19,530	line 17/18, col	1
2	Tom Jefferson	Asst Secretary/Treas	Management	10.00	390,860	5	100.00	Director/Salary	19,209	line 17/18, col	2
3	Craig Hart	Secretary/Treasurer	Management	20.00	343,058	10	100.00	Director/Salary	16,860	line 17/18, col	3
4	Joe Warner	President	Management	2.50	370,366	40	100.00	Director/Salary	18,202	line 17/18, col	4
5	Bob Dickson	Executive Vice Presid	Management	0.80	92,266	40	100.00	Salary	4,535	line 17, col 7	5
6	Cheryl Lowney	Executive Vice Presid	Management	0.30	186,564	50	100.00	Director/Salary	9,169	line 17/18, col	6
7	Steve Wannemacher	Executive Vice Presid	Management	0.30	175,068	50	100.00	Director/Salary	8,604	line 17/18, col	7
8	Connie Hoselton	Sr Vice President	Management	0.17	140,191	40	100.00	Salary	6,890	line 17, col 7	8
9	Craig Ater	Sr Vice President	Management	0.21	143,176	50	100.00	Salary	7,037	line 17, col 7	9
10											10
11											11
12											12
13								TOTAL	\$ 110,036		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor-Gillespie# 0041517

Report Period Beginning:

1/01/2002Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary	Beds	2,401	24	\$ 82,266	\$ 82,266	118	\$ 4,043	1
2	2 Food Purchase	Beds	2,401	24	0	0	118	0	2
3	3 Housekeeping	Beds	2,401	24	0	0	118	0	3
4	4 Laundry	Beds	2,401	24	0	0	118	0	4
5	5 Heat & Other Utilities	Beds	2,401	24	25,593	0	118	1,258	5
6	6 Maintenance	Beds	2,401	24	221,381	58,785	118	10,880	6
7	7 Other	Beds	2,401	24	0	0	118	0	7
8	9 Medical Director	Beds	2,401	24	0	0	118	0	8
9	10 Nursing & Medical Records	Beds	2,401	24	0	0	118	0	9
10	11 Activities	Beds	2,401	24	0	0	118	0	10
11	12 Social Service	Beds	2,401	24	0	0	118	0	11
12	13 Nurse Aide Training	Beds	2,401	24	45,737	39,267	118	2,248	12
13	14 Program Transportation	Beds	2,401	24	0	0	118	0	13
14	15 Other	Beds	2,401	24	0	0	118	0	14
15	17 Administrative	Beds	2,401	24	2,126,096	2,126,096	118	104,490	15
16	18 Directors Fees	Beds	2,401	24	112,849	0	118	5,546	16
17	19 Professional Services	Beds	2,401	24	212,454	0	118	10,441	17
18	20 Fees, Subscription, Promotions	Beds	2,401	24	87,500	0	118	4,300	18
19	21 Clerical & General Office Expense	Beds	2,401	24	4,472,002	4,183,145	118	219,782	19
20	22 Employee Benefits & Payroll Tax	Beds	2,401	24	584,769	0	118	28,739	20
21	23 Inservice Training & Education	Beds	2,401	24	18,362	0	118	902	21
22	24 Travel and Seminar	Beds	2,401	24	142,902	0	118	7,023	22
23	25 Other Admin. Staff Transportation	Beds	2,401	24	0	0	118	0	23
24	26 Insurance-Prop.Liab.Malpract	Beds	2,401	24	43,070	0	118	2,117	24
25	TOTALS				\$ 8,174,981	\$ 6,489,559		\$ 401,769	25

Facility Name & ID Number Heritage Manor-Gillespie# 0041517

Report Period Beginning:

1/01/2002Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27 Other	Beds	2,401	24	\$	\$	118	\$	1
2	30 Depreciation	Beds	2,401	24	210,090		118	10,325	2
3	31 Amortization of Pre-Op & Org	Beds	2,401	24			118		3
4	32 Interest	Beds	2,401	24	5,270		118	259	4
5	33 Real Estate Taxes	Beds	2,401	24			118		5
6	34 Rent-Facility & Grounds	Beds	2,401	24	161,349		118	7,930	6
7	35 Rent-Equipment & Vehicles	Beds	2,401	24	319,142		118	15,685	7
8	36 Other	Beds	2,401	24			118		8
9	38 Medically Nec Transportation	Beds	2,401	24			118		9
10	39 Ancillary Service Centers	Beds	2,401	24			118		10
11	40 Barber and Beauty Shops	Beds	2,401	24			118		11
12	41 Coffee and Gift Shops	Beds	2,401	24			118		12
13	42 Other	Beds	2,401	24			118		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 695,851	\$		\$ 34,199	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	National City		XX	Mortgage	\$28,143.00	03/01/96	\$ 3,385,859	\$ 2,978,931	01/15/06	variable	\$ 148,116	1							
2	National City Loan Amortization		XX	Mortgage							6,240	2							
3	Central Office Allocation		XX	Interest Income								3							
4	Alpha Community Bank		xx			05/01/01	104,710	83,769			4,188	4							
5												5							
	Working Capital																		
6	Central Office Allocation		xx	Working Capital							20,233	6							
7	Central Office Allocation		xx	Working Capital							259	7							
8												8							
9	TOTAL Facility Related				\$28,143.00		\$ 3,490,569	\$ 3,062,700			\$ 179,036	9							
	B. Non-Facility Related*																		
10	Interest Income										(44)	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (44)	14							
15	TOTALS (line 9+line14)						\$ 3,490,569	\$ 3,062,700			\$ 178,992	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Heritage Manor-Gillespie**# **0041517** Report Period Beginning: **1/01/2002** Ending: **12/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$ 25,130	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 25,199	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 69	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 26,459	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 26,528	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997	8	
	1998	9	
	1999	10	
	2000	11	
	2001	12	
			FOR OHF USE ONLY
			13 FROM R. E. TAX STATEMENT FOR 2001 \$ 13
			14 PLUS APPEAL COST FROM LINE 5 \$ 14
			15 LESS REFUND FROM LINE 6 \$ 15
			16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Gillespie COUNTY MACOUPIN

FACILITY IDPH LICENSE NUMBER 0041517

CONTACT PERSON REGARDING THIS REPORT Craig Ater

TELEPHONE (309) 823-7135 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>1000040001</u>	<u>Nursing Home</u>	\$ <u>25,128.00</u>	\$ <u>25,128.00</u>
2. <u>1000278402</u>	<u>Nursing Home</u>	\$ <u>71.00</u>	\$ <u>71.00</u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u><u>25,199.00</u></u>	\$ <u><u>25,199.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 33,800

B. General Construction Type:
 Exterior
 Brick/Wood
 Frame
 Number of Stories

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land			\$ 27,045	1
2					2
3	TOTALS			\$ 27,045	3

Facility Name & ID Number Heritage Manor-Gillespie

0041517

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	118				\$ 3,578,055	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof Repair			1997	2,275						9
10	Storage Tank			1997	1,857						10
11											11
12	Heritage Manor Sign			1996	1,896						12
13	Laundry Room A/C			1996	3,019						13
14											14
15	Garbage Disposal			1998	730						15
16	Roof			1998	90,404						16
17											17
18	Water Heater			1999	3,596						18
19	Air Conditioning Unit			1999	1,145						19
20	Smoke Dampers/Fire Alarm Replacement			1999	5,802						20
21	Interior Painting--Materials and Labor			1999	2,459						21
22	Roof			1999	29,985						22
23											23
24	Interior Painting--Materials and Labor			2000	3,923						24
25											25
26	Booster Heater			2001	1,903						26
27	Telephone System Add-on			2001	62						27
28											28
29	A/C Rooftop Unit			2002	2,703						29
30											30
31											31
32											32
33											33
34	C/O Allocation							10,325	10,325		34
35	Book Depreciation					93,766		93,766		628,779	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,729,814	\$ 93,766		\$ 104,091	\$ 10,325	\$ 628,779	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,729,814	\$ 93,766		\$ 104,091	\$ 10,325	\$ 628,779	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,729,814	\$ 93,766		\$ 104,091	\$ 10,325	\$ 628,779	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 434,238	\$ 60,875	\$ 60,875	\$		\$ 382,274	71
72	Current Year Purchases	11,351						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 445,589	\$ 60,875	\$ 60,875	\$		\$ 382,274	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,202,448	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 154,641	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 164,966	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,325	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,011,053	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 20,311 Description: pager, computer equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
	IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
	COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
	HOURS PER AIDE _____	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)		3,628		3,628	
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$ 3,628	\$	\$ 3,628	
10	SUM OF line 9, col. 1 and 2 (e)	\$ 3,628				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a/3	hrs	\$		\$ 24,684	\$		\$ 24,684	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			9,851			9,851	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			30,819	1,818		32,637	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				301,699		301,699	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): x-ray	39/3				8,960			8,960	13
14	TOTAL			\$		\$ 74,314	\$ 303,517		\$ 377,831	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Heritage Manor-Gillespie

0041517

Report Period Beginning: 1/01/2002

Ending:

12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,007	\$	1
2	Cash-Patient Deposits	3,444		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	314,601		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,624		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	857,414		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,190,090	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,045		13
14	Buildings, at Historical Cost	3,729,814		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	445,589		16
17	Accumulated Depreciation (book methods)	(1,011,052)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Tax Asset</u>	18,720		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,210,116	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,400,206	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 39,351	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,444		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	194,283		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,578		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,459		32
33	Accrued Interest Payable	13,935		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Security Deposits</u>	16,284		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 296,334	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,062,700		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,062,700	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,359,034	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,041,172	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,400,206	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 558,299	1
2	Restatements (describe):		2
3	<u>Audit Adjustment</u>	(18,599)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 539,700	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	501,472	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 501,472	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,041,172	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,985,897	1
2	Discounts and Allowances for all Levels	(405,489)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,580,408	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	133,888	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 133,888	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	5,485	11
12	Gift and Coffee Shop	3,659	12
13	Barber and Beauty Care	13,417	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	337,407	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	154	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 360,122	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	44	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 44	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,074,462	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	641,596	31
32	Health Care	1,666,899	32
33	General Administration	887,976	33
	B. Capital Expense		
34	Ownership	365,691	34
	C. Ancillary Expense		
35	Special Cost Centers	10,828	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	<u>Loss from Non-Nursing property</u>		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,572,990	40
41	Income before Income Taxes (line 30 minus line 40)**	501,472	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 501,472	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Page 20

Facility Name & ID Number Heritage Manor-Gillespie

0041517

Report Period Beginning: 1/01/2002

Ending:

12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,778	1,953	\$ 42,259	\$ 21.64	1
2	Assistant Director of Nursing	1,751	1,894	31,767	16.77	2
3	Registered Nurses	4,919	5,382	96,679	17.96	3
4	Licensed Practical Nurses	13,813	14,457	238,002	16.46	4
5	Nurse Aides & Orderlies	81,697	86,866	804,100	9.26	5
6	Nurse Aide Trainees	500	500	3,628	7.26	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,659	1,886	20,725	10.99	8
9	Activity Director					9
10	Activity Assistants	4,294	4,796	47,825	9.97	10
11	Social Service Workers	1,892	2,053	28,081	13.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,682	18,208	143,528	7.88	15
16	Dishwashers					16
17	Maintenance Workers	3,410	3,794	47,313	12.47	17
18	Housekeepers	11,445	11,969	81,553	6.81	18
19	Laundry	5,288	5,470	40,062	7.32	19
20	Administrator	2,080	2,080	65,915	31.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,513	6,274	90,568	14.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	156,721	167,582	\$ 1,782,005 *	\$ 10.63	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		1,250		36
37	Medical Records Consultant		50		37
38	Nurse Consultant				38
39	Pharmacist Consultant		690		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,198		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 5,188		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 6,577		50
51	Licensed Practical Nurses		1,877		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		\$ 8,454		53

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

****See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)**

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO no If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 64,605
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 820
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. not available at this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

